Total Cost of Care Workgroup

March 29, 2017

HSCRC
Health Services Cost Review Commission

Agenda

- Updates on initiatives with CMS
- Tentative timeline for VBM analytics and implementation
- Rough analyses on hospital-specific TCOC
- Examples of TCOC benchmarks and trending

Updates on Initiatives with CMS

Timeline for VBM analytics and implementation

VBM Timing

- Current expectation is for Medicare TCOC VBM to be in place by January 1, 2018
  - Thus, a final recommendation from HSCRC commissioners would be required by December 2017 Commission meeting
  - Draft recommendation is needed by November 2017 Commission meeting
- The VBM could be modified in future years
  - Current focus is on the start-up Year 1 (Performance Year 2018, Adjustment Rate Year 2020)
  - The structure of VBM in Performance Years 2019+ may be modified based on Phase 2 of the All-Payer Model, lessons learned in 2018, etc.

Tentative Timeline for VBM Analytics and Policy

Date	Topic/Action
March 29, 2017 (Today)	Rough analyses on TCOC measure and real-world examples of benchmarks
April 26, 2017	More in-depth analyses of TCOC potential measures and modeling, including geographic areas besides current PSAs
May 28, 2017	Potential benchmarking methodology (plus follow-up on TCOC measure refinement)
June 28, 2017	Potential financial responsibility and rewards (plus follow-up on benchmark and TCOC refinements)
TBD, 2017: Additional TCOC WG meetings?	Other follow-ups and outstanding issues
July 2017 – Sept 2017	Continue technical revisions of potential VBM policy with stakeholders
October 2017	Staff drafts RY 2020 VBM Policy
November 2017	Draft RY 2020 VBM Policy presented to Commission
December 2017	Commission votes on Final RY 2020 VBM Policy
Jan 1, 2018	Performance Period for RY 2020 Value-Based Modifier begins

VBM Implementation Timeline

Review of Interaction between Care Redesign Programs and VBM

1. VBM is intended to qualify Maryland hospitals to be Advanced APM Entities
2. Clinicians participating in Care Redesign Programs (CRP: HCIP, CCIP) with Maryland hospitals would be eligible to be Qualifying AAPM Participants (QPs)
3. QPs are eligible for a 5% bonus on their Medicare Part B services

VBM Timeline: RY2020 and RY2021

	Rate Year 2018		Rate Year 2019				Rate Year 2020				Rate Year 2021			
	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				CY2021	
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
Hospital Calculations	VBM RY2020 Performance Period				VBM RY2021 Performance Period				VBM RY2022 Performance Period					
Hospital Adjustment							VBM RY2020				VBM RY2021			
Clinician Participation	AAPM QP Eligibility for 2018				AAPM QP Eligibility for 2019				AAPM QP Eligibility for 2020					
Clinician Payments									2018 QP Bonus				2019 QP Bonus	

VBM Implementation Timeline:
RY2020 Walk Through

CY2018/RY2020 Walk Through: VBM

	Rate Year 2018		Rate Year 2019				Rate Year 2020				Rate Year 2021			
	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				CY2021	
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
Hospital Calculations	VBM RY2020 Performance Period													
Hospital Adjustment							VBM RY2020							
Clinician Participation														
Clinician Payments														

- The Performance Period for RY2020 VBM is Calendar Year 2018.
- RY2020 VBM adjustment occurs in RY2020 with July Rate orders.

CY2018/RY2020 Walk Through: VBM

	Rate Year 2018		Rate Year 2019				Rate Year 2020				Rate Year 2021			
	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				CY2021	
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
Hospital Calculations	VBM RY2020 Performance Period													
Hospital Adjustment							VBM RY2020							
Clinician Participation	AAPM QP Eligibility for 2018													
Clinician Payments									2018 QP Bonus					

- VBM performance period corresponds with the AAPM QP eligibility for 2018.
- 2018 AAPM participation allows for AAPM 5% bonuses to paid to clinicians in Jan 2020.

Rough analyses on hospital-specific TCOC

Primary Service Area (GBR PSA)

- MD Medicare FFS Beneficiaries for CY2013-2015
  - GBR PSA definition by zip code
  - National data is from the 5% sample
  - Does not include SAMHSA claims
  - Hospital PSA costs as a share of PSA TCOC varies from 2% - 48%; Avg 12%
  - See supplemental data for trend by PSA

GBR PSA	Period	Part A Hospital Trend	Part A Non Hospital Trend	Part B Hospital Trend	Part B Non Hospital Trend	Total per Capita Trend
		C	D	E	F	G
STATE AVERAGE	2014 over 2013	-2.9%	3.1%	-1.0%	0.5%	-0.6%
US AVERAGE	2014 over 2013	-1.8%	8.2%	-0.9%	0.9%	0.5%
		H	I	J	K	L
STATE AVERAGE	2015 over 2014	0.4%	4.1%	2.4%	3.4%	2.3%
US AVERAGE	2015 over 2014	0.0%	5.4%	0.2%	2.5%	1.6%

Stepwise: Hospital Episodes + PSA

- MD Medicare FFS Beneficiaries for CY2013-2015
  - Episodes capture all hospital costs plus 30 days post-acute for IP Stay or OP Major Surgery
  - Then remaining TCOC distributed through GBR PSA definition
  - Does not include SAMHSA Claims; no exclusions on episodes currently
  - Percentage of TCOC within-facility episodes ranges from 28% - 93%; 62% Avg
  - See supplemental data for trend by facility

Beneficiaries	Period	PERCENTAGE OF COST CAPTURED BY EPISODE	EPISODES PER K	COST PER EPISODE	EPISODES COST PER CAPITA	NON EPISODES PSA PER CAPITA	TOTAL COST PER CAPITA
			G	H	I	J	K
STATE AVERAGE	2014 over 2013	62.3%	3.4%	-4.3%	-0.9%	-0.1%	-0.6%
US AVERAGE	2014 over 2013						0.5%
			L	M	N	O	P
STATE AVERAGE	2015 over 2014	62.8%	-1.1%	2.5%	1.5%	3.6%	2.3%
US AVERAGE	2015 over 2014						1.6%

Issues to Consider in VBM Benchmark Design

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TCOC Work Group

March 29, 2017

Design issues in benchmark setting

- Two key questions:

1. Absolute vs. relative targets
2. Rewarding improvement vs. attainment/achievement

- Each approach has trade-offs
- What can we learn from the design of Medicare's value-based and alternative payment programs?

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Absolute vs. Relative Targets

- Absolute: Targets set prospectively
  - Pros: Give providers clear targets ahead of time – easier to work towards and measure progress during the year
  - Cons: May be challenging for state to set these targets
- Relative: Grade providers "on a curve" at end of year
  - Pros: Allow actual performance to determine rewards/penalties, does not require state to set targets, allows for budget neutrality where desired
  - Cons: Harder for providers to plan; if all improve, many will still receive penalties

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Improvement vs. attainment

- Improvement: Reward providers based on year-over-year improvement or improvement relative to baseline
  - Pros: Compares providers to own performance so incorporates any higher costs each provider may have (e.g., due to population served), baseline low performers benefit
  - Cons: May hurt providers who are relatively more efficient at baseline, may reach level beyond which improvement becomes increasingly challenging, could reward providers who may still be delivering sub-optimal care

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Improvement vs. attainment, cont.

- Attainment: Rewards based on absolute achievement
  - Pros: Efficient providers do best, allows for raising performance requirements more easily than improvement, can be more useful for reporting high-performers to consumers (increase transparency)
  - Cons: Necessitates accurate risk-adjustment, harder for baseline poorer performers
- Rewarding improvement or achievement will impact which providers stand to do well and poorly under the program
- Different requirements for risk-adjustment, implications for consumer "shopping"

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Current Maryland and Medicare Programs

Program	Absolute vs. Relative Targets	Rewarding improvement or attainment	Incentives as penalties or bonuses
Maryland Readmissions Reduction Incentive Program (RRIP)	Absolute	Both (improvement only until FY18)	Rewards and Penalties (up to 2%)
Maryland Quality-Based Reimbursement (QBR)	Relative initially, Absolute current	Both for score calculation	Rewards and Penalties (up to 2%)
Maryland Hospital Acquired Conditions (MHAC)	Absolute, statewide contingent scaling until FY17	Both for score calculation	Rewards and Penalties (up to 3%*)
Medicare Advantage Quality Star Rating Program	Relative	Both	Penalty (non-financial) and bonus (5%, financial)
Physician Value-Based Payment Modifier	Relative	Achievement only	Penalty and bonus (up to 2%)
Merit-Based Incentive Payment System	Relative	Both	Penalty and bonus (up to 9%)
Medicare Shared Savings Program	Combination (absolute for quality, relative for costs)	Both for quality, improvement only for costs (addition of blended regional '17)	Bonus only for track 1

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Example: MSSP

- Absolute or relative targets? **Combination (absolute for quality, relative for costs)**
- Reward improvement or achievement? **Both for quality, improvement only for costs**
- Cost benchmark based on three years of FFS expenditures for would-be-attributed beneficiaries
  - Calculated for Disabled, Dual, ESRD and risk-adjusted
  - Higher costs of some ACOs (e.g., due to population served) incorporated into benchmarks
  - Baseline higher-spending ACOs saved more
- Upcoming regional + own historical benchmark blend will introduce attainment-based reward

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Considerations

- Variation in how performance is measured and rewarded reflects different goals, challenges, opportunities of the program
- If a lot of variation and/or risk-adjustment likely to be challenging, rewarding improvement to start may be most effective; then can transition to blended approach with attainment (e.g., MSSP)
- All of Maryland's Performance-Based Measurement Programs aim to be prospective and are based on absolute, not relative performance.

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TCOC Work Group Meeting Dates

- **April 26, 2017, 8AM-10AM**
- May 28, 2017, 8 AM – 10 AM
- June 28, 2017, 8 AM – 10 AM
- TBD, 2017: Additional TCOC WG meetings?

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